

ATCMA Program – Preferred TCM Practitioners Program

PROPERTY AND COMMERCIAL GENERAL LIABILITY APPLICATION

APPLICANT'S LEGAL NAME:													
OPERATING NAME:													
NAME OF ALL SUBSIDIARIES AND AFFILIATES THAT INSURANCE IS TO BE INCLUDED:													
TYPE OF ORGANIZATION:	<input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Individual <input type="checkbox"/> Other _____ Operations of the Clinic include: <input type="checkbox"/> Herbalist (R.TCM.H) <input type="checkbox"/> Acupuncturist (R.Ac) <input type="checkbox"/> Traditional Chinese Medicine Practitioners (R.TCM.p) and Doctors of TCM (Dr. TCM) <input type="checkbox"/> Massage Therapy <input type="checkbox"/> Acupoint Injection Therapy <input type="checkbox"/> Supervised Students (s) if yes, how many _____ Others:												
PHONE NUMBER:													
EMAIL:													
MAILING ADDRESS:													
INSURED LOCATION ADDRESS:													
WEBSITE:													
YEAR INCORPORATED:													
DATE COVERAGE REQUIRED:													
ATCMA MEMBERSHIP STATUS:	Are you a member in good standing with the ATCMA? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide Membership No. _____												
CTCMA MEMBERSHIP STATUS:	Are you a member in good standing with the CTCMA? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide Membership No. _____												
SUPERVISED STUDENTS:	Do you supervise any students during their training sessions? <input type="checkbox"/> Yes <input type="checkbox"/> No												
ADDITIONAL PRACTITIONERS:	Do you have any other practitioners working with you? <input type="checkbox"/> Yes <input type="checkbox"/> No												
	If you are the principal of the clinic and have employees/independent contractors working in the clinic, please provide the following information:												
	<table border="1"> <thead> <tr> <th>Name of Practitioner</th> <th>Professional Designation (R.Ac, Dr. TCM, etc.)</th> <th>Does he or she carry Professional Liability insurance? (Yes or No)</th> </tr> </thead> <tbody> <tr> <td>1.</td> <td></td> <td></td> </tr> <tr> <td>2.</td> <td></td> <td></td> </tr> <tr> <td>3.</td> <td></td> <td></td> </tr> </tbody> </table>	Name of Practitioner	Professional Designation (R.Ac, Dr. TCM, etc.)	Does he or she carry Professional Liability insurance? (Yes or No)	1.			2.			3.		
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1.													
2.													
3.													

	4.								
CONTINGENT PROFESSIONAL LIABILITY:	If you are the principal of this clinic, would you like to add Contingent Professional Liability insurance? <i>This provides coverage in the event of a claim being made by one of your employees/independent contractors working in your clinic.</i> <input type="checkbox"/> Yes <input type="checkbox"/> No								
CONTINGENT PROFESSIONAL LIABILITY LIMITS:	If you responded yes to the above, please advise the limits you would like to add: <input type="checkbox"/> \$1,000,000 <input type="checkbox"/> \$2,000,000 <input type="checkbox"/> \$3,000,000 <input type="checkbox"/> \$5,000,000								
CONTINGENT PROFESSIONAL LIABILITY PREMIUMS:	<table border="1"> <tr> <td>\$1,000,000:</td> <td>\$2,000,000:</td> <td>\$3,000,000:</td> <td>\$5,000,000:</td> </tr> <tr> <td>\$1,100</td> <td>\$1,452</td> <td>\$1,755</td> <td>\$2,420</td> </tr> </table>	\$1,000,000:	\$2,000,000:	\$3,000,000:	\$5,000,000:	\$1,100	\$1,452	\$1,755	\$2,420
\$1,000,000:	\$2,000,000:	\$3,000,000:	\$5,000,000:						
\$1,100	\$1,452	\$1,755	\$2,420						
MANUFACTURING:	Do you manufacture any products? <input type="checkbox"/> Yes <input type="checkbox"/> No Do you undertake any work away from your business premises as stated above? <input type="checkbox"/> Yes <input type="checkbox"/> No								

LOCATION

LOCATION ADDRESS:	Loc # _____	Loc # _____	Loc # _____
LOCATION OWNED/LEASED BY YOU:	<input type="checkbox"/> owned <input type="checkbox"/> leased	<input type="checkbox"/> owned <input type="checkbox"/> leased	<input type="checkbox"/> owned <input type="checkbox"/> leased
LOCATION LEASED/RENTED:	If own the building you operate out of, do you lease or rent the space to others? <input type="checkbox"/> rent <input type="checkbox"/> lease		
YEAR BUILT:			
NO. OF STOREYS:			
CONSTRUCTION TYPE	Loc # _____ <input type="checkbox"/> Frame <input type="checkbox"/> Concrete <input type="checkbox"/> Fire Resistive	Loc # _____ <input type="checkbox"/> Frame <input type="checkbox"/> Concrete <input type="checkbox"/> Fire Resistive	Loc # _____ <input type="checkbox"/> Frame <input type="checkbox"/> Concrete <input type="checkbox"/> Fire Resistive

PROTECTION

	Loc # _____	Loc # _____	Loc # _____
BUILDING SPRINKLERED:	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
% OF BUILDING SPRINKLERED	%	%	%
CONNECTED TO ALARM?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
BURGLAR ALARM:	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
CENTRAL OR LOCAL	Central <input type="checkbox"/> Local <input type="checkbox"/>	Central <input type="checkbox"/> Local <input type="checkbox"/>	Central <input type="checkbox"/> Local <input type="checkbox"/>

INSURABLE VALUES

BUILDING (not applicable if leased):	\$	\$	\$
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LEASEHOLD IMPROVEMENT:	\$	\$	\$
OFFICE CONTENTS (including equipment, furniture, computer hardware/software/laptops)	\$	\$	\$
STOCK (actual cash value)	\$	\$	\$
BUSINESS INTERRUPTION (net profits plus standing charges*) – Optional coverage	\$	\$	\$
- 12 Months INDEMNITY PERIOD	12 months	months	months

*Note: standing charges means the expenses that can not be eliminated when there is a partial or total loss of the property, which results in the business interruption. Examples are rents, utility charges, key employees wages, etc.

REVENUES				
DESCRIPTION OF APPLICANT'S OPERATIONS AND ANNUAL SALES (Please breakdown by different services or product sales)	Services/Product Sales			Annual Revenue
				\$
				\$
				\$
COMMERCIAL GENERAL LIABILITY LIMITS REQUIRED:	<input type="checkbox"/> \$1,000,000 <input type="checkbox"/> \$2,000,000 <input type="checkbox"/> \$3,000,000 <input type="checkbox"/> \$5,000,000			
COMMERCIAL GENERAL LIABILITY PREMIUMS:	\$1,000,000 \$207	\$2,000,000 \$273	\$3,000,000 \$330	\$5,000,000 \$457

CLAIMS HISTORY (Please provide details of all Losses in the past 5 years and (including legal defence costs))					
DATE OF LOSS	CLAIMS STATUS (OPEN / CLOSED)	DESCRIPTION OF LOSS	RESERVE	AMOUNT PAID	DEDUCTIBLE
			\$	\$	\$
			\$	\$	\$

- Are you aware of any other incidents which may result in a claim(s) against you? Yes No
- If Yes, please provide details:
- In the past, have you ever been the recipient of any allegations of professional negligence in writing? Yes No
- If Yes, please provide details:

PREVIOUS POLICY				
PREVIOUS INSURER:	POLICY NUMBER:	EXPIRY DATE:	POLICY TYPE: (PACKAGE, CGL, OR PROFESSIONAL)	CLAIMS MADE OR OCCURRENCE FORM?

1. In the past 5 years, has any Insurer refused, non-renewed or cancelled any liability policies? Yes No
2. If Yes, please provide details:

SIGNATURE *Please sign below where indicated:*

I/We declare that statements made herein are in every respect true and correct and hereby apply for contract insurance to be based upon the truth of said statements.

X

Signature of Signing Officer (Applicant)

X

Title of Signing Officer

X

Print Name of Signing Officers (Applicant)

X

Date Signed: